DOCUMENT RESUME

ED 197 199 CE 027 845

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TITLE Mandatory Continuing Education Debate: The Perceptions of Maryland Dentists.
PUB DATE Feb 81
NOTE 16p.; Paper presented at the Lifelong Learning Research Conference (College Park, MD, February 6-7, 1981).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Attitudes; *Certification; *Continuing Education; *Dentists; Professional Associations; *Professional Continuing Education; Relevance (Education); Research Needs; *Standards; Surveys
IDENTIFIERS Maryland

ABSTRACT

A study was conducted to determine the attitudes of Maryland dentists toward mandatory continuing education (MCE) for re-licensure, a provision that has been the subject of debate among the professions for the past fifteen years. After a review of the literature, which revealed many arguments pro and con mandatory continuing education, a questionnaire was developed and sent to 630 randomly selected dentists who were members of the Maryland State Dental Association (one-third of the membership); 335 questionnaires were returned. Findings showed that those who opposed MCE tended to be older and to spend less time than the mean on continuing education. Younger dentists and those who spent more time on continuing education tended to favor MCE more strongly, although even here, support was expressed by just over half of the dentists surveyed. Reasons given by proponents of MCE were to keep up on developments in the field and that some dentists would not take continuing education unless required to do so. Those who opposed MCE cited opposition to controls, lack of relevance of courses, and feelings that professionals would keep up without being forced, among other reasons. Implications of the study include a need for further research to show the relevance of MCE to improved practice, need for development of courses according to needs expressed by members of the profession, and further study of number of hours required and number of hours dentists are already taking voluntarily. (KC)

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Paper presented at 1981 Lifelong Learning Research Conference,
February 6-7, Center of Adult Education, University of Maryland
College Park, Maryland

CE027845

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THE MANDATORY CONTINUING EDUCATION DEBATE: THE PERCEPTIONS OF MARYLAND DENTISTS

by

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Mandatory continuing education (MCE) has been a controversial issue in professional circles for the past fifteen years. Its proponents assume that making continuing education mandatory will guarantee, or at least increase the likelihood of, increased professional competence. This is particularly true in the health care field. Some consumers of professional services view MCE as a mechanism through which the public can exercise a degree of control over the products of its specialists who otherwise answer only to themselves. Professionals have suggested that, in some cases, MCE protects them from the damage of their less competent colleagues who are forced to keep up with recent developments in their field, whether they like it or not. Many adult educators have jumped on the MCE bandwagon as their raison d'etre.

The opposition to mandatory continuing education comes from several quarters. Some argue that MCE is antithetical to professionalism. Some maintain that MCE is an unwarranted intrusion by government on individual freedom. The net effect, this argument holds, is the creation of yet another instrument through which the society's elite extend their control over powerless, ordinary people. Still others believe that genuine professionals will voluntarily participate in meaningful learning activities--attend professional meetings, take relevant courses, read the professional literature, consult with

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knowledgeable colleagues, etc.--without the threat of outside sanctions. If continuing education programs are not valued by professionals in the field, this position would suggest the solution is to improve the quality of the teaching/learning process. From this perspective, making irrelevant and uninteresting continuing education programs mandatory is an excuse for ignoring the underlying issues of how professionals learn about new developments in their fields.

While the debate rages, usually on philosophical grounds, research is needed to assess how professionals themselves view mandatory continuing education. This paper reports the findings of a study that examined the views of Maryland dentists regarding mandatory continuing education as a requirement for relicensure. Specifically, it focuses on the relationship of age, voluntary involvement in continuing education, participation in their professional societies, and the hours dentists spend on their practices, to dentists' views of MCE. The findings may suggest some implications for educators, professional societies and institutions delivering continuing education programs.

Defining the Issue: Views from the Literature

Although the purpose of this paper is not to argue a particular philosophical perspective, a cursory review of the literature may clarify the dimensions of the mandatory continuing education debate. Houle's review of definitions of professionalism reveals some common themes. The concept implies a high level of formal education, specialized knowledge that is highly valued and assumes a degree of altruism on the part of the professional (Houle, 1980: 19-33). Goode views professionals as a closely-knit community within a community--a community that demands a high degree of education among its members (1957).

Since evaluation within the professions is generally considered to be the perogative of those who share that expertise, there is little external accountability. Where one's professional competency is defined by one's peer within a closed community, and not by the clients of a service, the profession has a high degree of autonomy. Goode suggests that professionals generally will not criticize their colleagues before lay persons on the assumption that it would negatively reflect upon the profession itself (1957: 194-200). Houle, in fact, points out that the sudden decline of professions in the public esteem accompanied the growth of criticism within the memberships of professional groups (1980: 268).

Where members of the fraternity are reluctant to criticize each other, licensure is perceived as a mechanism through which the public can exercise a degree of control over the quality of the services provided to the public, in spite of the professional's relative autonomy. At the same time, the proliferation of professionals has also reduced their status in society to the point where Stern speaks of a "professional peasantry" of which nearly everyone considers themselves to be a member (1977: 228).

Houle, though not an advocate of mandatory continuing education, suggests several reasons why it has been so well-received. First, the professions allegedly fail to provide their services to the poor and socially disenfranchised. Secondly, the professions are perceived as placing their own self-interest ahead of the public welfare. Thirdly, the professions are allegedly incompetent, inattentive, dogmatic, faddish, cold and impersonal, ignorant of new ideas and practices, and fail to monitor quality (1980: 271). In this vein, Frandson argues for mandatory continuing education, suggesting that relicensure laws should be worded so that a significant amount of continuing education is

taken through the accredited college or university where learners would be exposed to the results of pure research (1979: 5-10). He assumes, of course, that this would improve the quality of services available to the public.

Illich, on the other hand, believes that learning must be self-directed to be effective and therefore maintains that most education occurs outside the formal setting. In contrast to this view, he suggests, society teaches, "...that valuable learning is the result of attendance; that the value of learning increases with the amount of input; and finally that this value can be measured and documented by grades and certificates" (1972: 56). Once we accept school and its implicit control, we set ourselves up for other controls which inhibit innovativeness, imagination and progress (1972: 56-57).

Rockhill takes the argument against mandatory continuing education a bit further, suggesting that there is no proven relationship between this kind of educational activity and professional performance. Not only is it antithetical to the basic principles of adult education--learner involvement, voluntary participation, etc.--it is often self-serving to professional educators since it is their livelihood (1977: 37). The same theme runs through some of the literature in the health professions.

The Ad Hoc Committee on Continuing Medical Education of the Association of American Medical Colleges expressed its opposition to mandatory continuing education on several grounds. First, MCE disregards the fact that physicians are adult learners. Second, the priorities of the teachers and teaching institutions outweigh those of the physicians in an MCE context. Third, MCE provides little opportunity for physicians to express their own initiative in the learning process. Finally, there is little evidence of any significant relationship between learning and practice behavior within the framework of mandatory continuing education (1980: 153).

A survey of Pennsylvania physicians indicated that at least half favor specified levels of continuing medical education for professional society membership. However, more than 80% claimed that they would have studied just as much, even if continuing education had not been mandatory. More than 75% reported that they did not need formal education programs because their own reading in professional journals and participation in conferences were adequate for keeping them abreast of new developments in the field (Second Thoughts, 1980: 7).

This contradiction is equally clear in the dental profession. On the one hand, Loveland favors MCE, arguing that those who need it most are the least likely to seek it (1979: 330). Morris, on the other hand, is "...violently opposed to robbery, arson, murder, and compulsory continuing education" (1979: 30). Dentistry, he continues, is threatened by mandatory continuing education as much as by discount-store dentists, advertising and denturism (1979: 30). Loveland, however, says that mandatory continuing education has not hindered the practice of dentistry in those states which have mandated it (1979: 330).

About the only definitive conclusion that one can draw from the literature is that this divergence of views regarding continuing education is broad and deeply held. While more research is needed to assess the effect of continuing education upon the quality of services delivered, a more modest starting point is to determine how professionals view mandatory continuing education within their own field.

Methodology

The Maryland State Dental Association authorized this study through its Long Range Planning Committee as part of its mandate to improve services to its members. This committee identified a series of questions that were

synthesized into nine items designed to elicit the views association members hold of the organization and its mandate. Several questions used by the Illinois State Dental Society in a similar survey to evaluate the services of that state association were included in the instrument, together with additional items dealing with mandatory continuing education.

The state association includes ten local/regional groups called component societies. Following a pretest involving two respondents from each component society, a thirty-three percent stratified, random sample was drawn. Of the nearly 2,000 members of the State Dental Association, 630 were sent questionnaires, of which 335 were ultimately returned.

The quantitative data were analyzed through the use of frequency tables and the chi square statistic to determine the extent to which the respondents revealed significant differences in their views of mandatory continuing education for relicensure. Several open-ended questions provided an opportunity for dentists in the sample to further express their views regarding the role of the state association in providing continuing education.

A combination of factors including the involvement by the planning committee in designing the instrument and cover letters by the association's president and executive director sparked considerable interest in this study and probably explains the relatively high rate of return of the questionnaires. While some open-ended questions were largely ignored by the respondents, both the instrument and the sample had at least a degree of face validity.

A review of the findings suggests some interesting conclusions.

The Findings

The data reveal some striking differences in perceptions of mandatory continuing education for relicensure among members of the Maryland State Dental Association.

Age

Table 1 reveals a statistically significant relationship (at the .05 level) between the age of dentists and their views of mandatory continuing education.

TABLE 1

Age and Views of Mandatory Continuing Education for Relicensure

Age	For		Against		No Response	
	No.	Percent	No.	Percent	No.	Percent
Under 40	77	51.7	65	43.6	7	4.7
40-59	61	40.7	82	54.7	7	4.7
60 and over	6	16.7	28	77.8	2	5.6
Total	144		175		16	

Chi Square: 5.44 Significance: .0039

Although 52% of the overall sample opposes mandatory continuing education for relicensure, just over half of the dentists under the age of 40 support it. Dentists in the middle-age category, on the other hand, generally oppose MCE while the older dentists strongly reject the concept. This may perhaps be explained by the fact that older dentists are reluctant to participate in courses near the end of their careers while younger ones may feel more pressure to keep abreast of recent developments in anticipation of longer remaining careers.

Hours of Continuing Education

The literature indicates that many who oppose mandatory continuing education believe that professionals can and will study and learn on their own without the threat of losing their license. This would suggest that MCE is

unnecessary, apart from whatever philosophical reasons one might give for opposing the concept. To determine whether there is a relationship between participation in continuing education programs and views of relicensure, the instrument included a question assessing the number of hours that respondents spend in continuing education each year. The results are shown in the following table.

TABLE 2

Hours of Participation in Continuing Education Per Year and Views of Mandatory Continuing Education for Relicensure

Hours of Continuing Education per year	For		Against		No Response	
	No.	Percent	No.	Percent	No.	Percent
0-15	37	31.9	72	62.1	7	6.0
16-50	83	48.0	82	47.4	8	4.6
51-99	24	52.2	21	45.7	1	2.2
Total	145		175		16	

Chi Square: 9.57 Significance: .05

The table shows a statistically significant relationship (at the .05 level) between the hours of continuing education taken per year and the views Maryland dentists hold regarding mandatory continuing education for relicensure. Those reporting fifteen or less hours of continuing education per year strongly oppose making it mandatory, while dentists who participate the most expressed a degree of support. Those in the middle were split almost evenly. These findings are consistent with the responses to several open-ended questions in which some argued that while they personally kept up with recent developments in the field through participation in continuing education programs, their less motivated colleagues would require additional pressure before investing much time in teaching/learning activities.

Hours Practiced Per Week

The survey revealed some major differences in the amount of time dentists spend in their practice. While it is tempting to hypothesize that those who practice part-time would be less disposed toward mandatory continuing education than full-time professionals, this difference was not found to be statistically significant.

Participation in Professional Society Activities

Professional societies provide various mechanisms through which their members can participate in continuing education. The Maryland State Dental Association is no exception. Several questions attempted to ascertain whether those who are active in their professional societies differ from their less active colleagues in their views toward mandatory continuing education.

The data suggest that dentists who have served as chairpersons of state association councils and committees tend to oppose mandatory continuing education more than non chairpersons. However, since committee leaders are generally older than non-leaders--it takes time to develop the senior standing expected of leaders--the salient variable is probably age and not status. In any case, the apparent relationship is not statistically significant.

At the local level, the data reveal no differences in the views of mandatory continuing education between dentists who had served as leaders in their component societies and those who had not. However, officers in component societies were found to participate more in continuing education programs than do their colleagues who were non-officers. This can undoubtedly be explained by the fact that officers are generally expected to attend component-sponsored educational activities which are frequently held in conjunction with local society meetings. Leadership at the component level and participation in continuing education, therefore, tend to run hand-in-hand.

The study also found no significant difference in attitudes toward MCE between dentists who had served on committees at the component level and those who had not. However, as in the case of those in leadership positions, committee members reported more hours of participation in continuing education than did their noncommittee member colleagues.

Arguments For and Against MCE

Dentists favoring mandatory continuing education were asked to explain the rationale for their views. Their responses were collapsed into several categories and cross-tabulated with age as can be seen in the following table.

TABLE 3

Age and the Rationale for Mandatory Continuing Education

Age	Keep up with Profession		Force Non-participants to Participate		Increase Competence		Improve Care	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Less than 40	30	20.1	14	9.4	14	9.4	17	11.4
40-59	29	19.3	10	6.7	10	6.7	8	5.3
Over 60	2	5.6	3	8.3	1	2.8	0	0
Total	61		27		25		25	

The most commonly reported rationale for advocating mandatory continuing education was that it provided a means for keeping up with the profession. Although the small size of several cells in the table means that a chi square statistic would be of questionable validity, there is little apparent difference between the arguments used by individuals in the three age groups to explain their support for MCE.

Those dentists opposed to MCE were asked to give their reasons as well. The results appear in the following table.

TABLE 4

Age and the Argument Against Mandatory Continuing Education

	Arguments Against MCE							
	Oppose Controls		Poor Quality of Continuing Ed. Courses		Difficult to Administer Mandatory Prog.		Can't Force Dentists to Learn	
Age	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Less than 40	11	7.4	13	8.7	7	4.7	16	10.7
40-59	25	16.7	13	8.7	3	2.0	17	11.3
Over 60	5	13.9	6	16.7	2	5.6	6	6.7
Total	41		32		12		39	

Table 4 reveals significant differences between age groups in their reasons given for opposing mandatory continuing education for relicensure. Younger dentists opposed to MCE argued that people cannot be forced to learn against their will while those in the middle category objected to the whole notion of controls in and of themselves. Older dentists, however, were evenly split, with a proportionately larger number concerned about the allegedly poor quality of continuing education programs. Twenty-six percent of those opposing mandatory continuing education gave as their reason the poor quality of continuing education programs. The qualitative statements in the instrument revealed that some continuing education programs are considered a "waste of time", "paid vacations", or worse. Increasing the quantity will not improve the quality, nor increase the interest of these respondents in further participation.

Discussion and Implications

As of 1979, eleven state dental boards had continuing education requirements for relicensure as part of state law. While there is no immediate prospect of similar legislation in Maryland, it should be noted that the mean number of

hours spent by respondents in this sample (approximately 28 hours) is higher than any other state's requirements for relicensure (American Dental Association, 1977). Therefore, the argument that mandatory continuing education is needed to force dentists to continue studying is rather tenuous. While some dentists apparently wish to make the potential Maryland requirement more stringent than those currently in existence in other states, the rationale for this proposal appears to be rather arbitrary.

The data in this study showed that older dentists objected most strongly to the notion of mandatory continuing education and participated less in current programs than their younger colleagues, probably because of the limited time that they anticipate continuing to practice dentistry. The solution, should MCE legislation be proposed in Maryland in the future, might be to follow the lead of New Mexico which exempts dentists over sixty-five years of age from any continuing education requirements.

Although professional societies exist for a variety of reasons, most assume major responsibility for providing continuing education services to their members. A resolution was introduced at the 1980 Maryland State Dental Association meetings that recommended support for mandatory continuing education for relicensure. The resolution, which ultimately did not pass, suggested that dentists receive five hours of credit for attendance at multi-day meetings with another two hours credited for special sessions within such a meeting. Attendance at special breakfasts, luncheons and dinners would also count toward the continuing education requirement proposed by the association.

Using these criteria, it would have been possible for participants in the 1980 State Dental Association meetings to fulfill eleven hours of the proposed fifteen hour requirement by simply attending selected parts of the three-day annual conference in Baltimore. On the one hand, this suggests that professional

societies need to make their continuing education opportunities readily available to their members if legislation ever makes participation a prerequisite for relicensure. On the other hand, this may indicate that such a requirement may generate innovative ways to circumvent the original intent of this legislation.

An alternative approach may be to develop more interesting and useful continuing education programs based on the expressed needs of practicing dentists. Placing continuing education in a proactive, rather than reactive, stance would not only be more consistent with the basic principles of adult education, but could potentially improve its image among Maryland dentists. While the assumption that participation in continuing education improves the quality of professional services rendered has not been adequately tested, programs based on needs identified by dentists themselves at least increases the possibility that this will happen.

A more salient implication, on the other hand, may be to develop innovative delivery systems through which continuing education programs can easily be made available to professionals in the field, particularly in outlying areas. Some possibilities include developing regular teleconference seminars, traveling regional workshops, the use of public broadcasting, and increased programmed instruction through audio and video tapes.

Conclusion

While the findings of this study examining the views of mandatory continuing education held by Maryland dentists are not conclusive, they are consistent with the ambiguity in the literature. Although the issue needs further debate on philosophical grounds, more studies testing the extent to which mandatory continuing education actually generates improved services in

the professions are needed. Professional societies must demonstrate that their members are in fact accountable to the public or the clamor for relicensure will increase. The resulting legislation would probably be written by persons outside the profession. The alternative is to improve the quality and the quantity of voluntary continuing education whose result could well be an increase in the level of public confidence.

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